CareDentistry
IcDentist.com

CONFIDENTIAL

We are happy to welcome you to our office! Please completely fill out this form and if you have any questions, we will be glad to help you!

Patient Information

Date_____

Patient's last name_____ First name_____ Middle initial_____

Prefers to be called_____ Date of Birth _____ Sex ☐ Male ☐ Female

Social Security# _____ School_____

Email address(es) _____

Home address _____ City, State, Zip code_____

Home phone ( ) _____ Cell phone ( ) _____

Parent / Guardian (if patient is under 18)

Custodial parent(s) name(s)_____

Patient lives with (check all that apply) ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s)

O Other_____

Primary Guardian Full Name_____Date of Birth_____

Occupation_____ Email address_____

Address (if different)_____

Home Ph. ( )_____ Cell Ph. ( )_____ Work Ph. ( )_____

Secondary Guardian Full Name_____Date of Birth_____

Occupation_____ Email address_____

Address (if different)_____

Home Ph. ( )_____ Cell Ph. ( )_____ Work Ph. ( )_____

Financial Responsibility

Who is financially responsible for this account?_____

Address_____

City _____ State_____ Zip code_____

Home phone ( )_____ Cell phone ( ) _____

Email address(es)_____

Social Security #_____ Employer_____

Who will be responsible for bringing the patient to appointments? _____

Dental / Orthodontic Insurance

Primary policy holder's full name_____ Date of Birth_____

Social Security #_____ Relationship to patient_____

Address and phone (if not listed above)_____

Employer_____ Address_____

Insurance company _____ Group #_____ ID#_____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary policy holder's full name_____ Date of Birth_____

Social Security #_____ Relationship to patient_____

Address and phone **(if not listed above)**_____

Employer_____ Address_____

Insurance company _____ Group #_____ ID#_____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary Insurance

Primary policy holder's full name_____ Date of Birth_____

Social Security #_____ Relationship to patient_____

Address and phone (if not listed on front.)_____

Employer_____ Address_____

Insurance company _____ Policy #_____ ID#_____

Secondary policy holder's full name_____ Date of Birth_____

Social Security #_____ Relationship to patient_____

Address and phone (if not listed on front.)_____

Employer_____ Address_____

Insurance company _____ Policy #_____ ID#_____

Physician

Patient Physician _____ City, State_____

Last seen_____ Reason_____ Next appointment_____

Most recent physical exam_____

Other physicians/health care providers being seen now:

Name_____ City, State_____

Reason_____

Name_____ City, State_____

Reason_____

Notice of Privacy

Acknowledgment of Receipt of Notice of Privacy Practices Posted. Copies available upon request.

I have read over this office's Notice of Privacy Practices records and materials.

X _____ _____

Patient/Guardian Signature Date

---------- For Office Use Only ----------

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ **Individual refused to sign ( ) Communication barriers prohibited obtaining acknowledgment.**

☐ **An emergency situation prevented us from obtaining acknowledgment. ( ) Other (Specify)** _____

Authorization

I authorize the Provider to release any information including the diagnosis and records of treatment or examination rendered to the patient during the period of such are to third party payers and/or other health practitioners. I authorize and request my insurance company to assign benefits and pay directly to the Provider or Provider's group those insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I authorized the use of my signature on all insurance submissions. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ _

Patient/Guardian Printed Name

X _____ _____

Patient/Guardian Signature Date